

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First VERA			Middle SHORES			Last BENTON			2a. DATE KNOWN OF DEATH Month Feb. Day 20 Year 1968			2b. HOUR 10:35		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 24, 1891		6. AGE (in years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month _____ Day _____ Year 19			2d. HOUR M		
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Dorchester				Md.	
10. CITY OR TOWN OF DEATH Cambridge				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Dorchester				13c. CITY OR TOWN Cambridge				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 308 Belvedere Avenue			
14. FATHER'S NAME First William ? Middle Shores Last _____						15. MOTHER'S MAIDEN NAME First Margaret ? Middle Tyler Last _____											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. John Trader, Cambridge, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 884X (b) Fracture neck r. femur DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant 8 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9037																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1.30PM 2/12/68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Slipped getting out of bed									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ Cambridge Hosp. Cambridge Dor. Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>John Mace Jr.</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED 2/22/68					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Feb 22 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park				23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland							
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
02547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02533										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Bertha E. Cephas						Month Day Year		8A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Female	Negro	1913	54 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year	8A M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia		USA				Dorchester		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			DOA Cambridge Md. Hosp.			Domestic		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Moore's St. Ext.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Unknown			Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No					Mary Spicer Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2/26/68				
John Mace Jr. M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Cambridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			2/26/68		Mission Cemetery		Dorchester, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Booker M. West					DATE MAR 1 1968		J. Charles Jones			

7230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02548 CERTIFICATE OF DEATH 02534									
1. DECEASED-NAME (Type or print) GEORGE			First Middle Last COOK, Jr.			2a. DATE OF DEATH Month Day Year Feb 23 1968		2b. HOUR A.M. 2:15	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 13, 1882		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bookkeeper-Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN Madison		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Deep Point	
14. FATHER'S NAME First Middle Last George Cook, Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Gray						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No (If yes give war or dates of service) - - -			16b. SOCIAL SECURITY NO. - - -		17. INFORMANT Address Mrs. Walter D. North, Woolford, Md. 21677				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & thrombosis 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerosis gen								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days ? ?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331.9									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 16, 1968 , to Feb 23, 1968 , that (I) (we) last saw the deceased alive on Feb 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James U. Thompson					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/24/68		
22d. PHYSICIAN'S NAME (Type) James U. Thompson, MD					22e. ADDRESS Locust St., Cambridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones		

0334

0334

DATE	TIME	FROM	TO
Aug. 17, 1962	10:00 AM	WASH DC	NEW YORK

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

NAME	ROOM	STATUS
Mr. J. Edgar Hoover	Room 5612	Occupied

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV. 1/68

02549										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02535																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
Raymond Dennis										2 Month 11 Day Year 68										6:40 AM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS. HOURS MIN.									
male										White										12-18-82										88 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
MD.										U.S.A.																				Dorchester																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Cambridge Md.										Eastern Shore State																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
MD.										Wicomico										Willards										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										Willards, MD.																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
EPHRIAM WILSON DENNIS										MARIA ANN DENNIS																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
																				Eastern Shore State Hosp.										Cambridge, MD.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										ASPIRATION PNEUMONITIS										1 DAY																																							
486X																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) UREMIA										1 YEAR																																							
492X																																																											
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
SENILE DEMENTIA																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (this hospital) attended the deceased from AUG 28, 1957 to FEB 11, 1968, that (I) (we) last saw the deceased alive on 2-11-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										EDWARD LEWIS, MD										22c. DATE SIGNED																																							
																				2-11-68																																							
22d. PHYSICIAN'S NAME (Type)										EDWARD LEWIS, MD										22e. ADDRESS																																							
																				ESSH, CAMBRIDGE, MD																																							
23a. BURIAL, CREMATION, BURNING, SPECIALLY										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										2/13/68										WILLARDS										WILLARDS Wicomico MD.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
																				DATE FEB 15 1968										Charles Judge																													

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THE UNIVERSITY OF CHICAGO

LIBRARY

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CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print) Archic Foreman			2a. DATE OF DEATH FEB Month 10 Day 68 Year		2b. HOUR 3:39 M.
3. SEX Male	4. RACE Coloideed	5. DATE OF BIRTH 12-23-98		6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Dorchester Md.		
10. CITY OR TOWN OR DEATH Cambridge Maryland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farm work		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY Worcester	13c. CITY OR TOWN Berlin	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.T.D.3 Berlin, Md.	
14. FATHER'S NAME First Middle Last Charles Foreman			15. MOTHER'S MAIDEN NAME First Middle Last Julie Leonard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Eastern Shore State, Camb., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 347.9 DUE TO, OR AS A CONSEQUENCE OF (b) DEHYDRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CHRONIC BRAIN SYNDROME					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 1 WK 1+ YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 309X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from FEB 9, 1968 , to FEB 10, 1968 , that (I) (we) last saw the deceased alive on FEB 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sean M. Killoran MD				22c. DATE SIGNED FEB 10, 1968	
22d. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN				22e. ADDRESS 7415 BLAIR RD, WASHINGTON, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 2-15-68		23c. NAME OF CEMETERY OR CREMATORY St. Peters	
23d. LOCATION (City or Town) (County) (State) NEWARK - WORC. MD.		24. FUNERAL DIRECTOR Holden			
25a. REC'D BY REGISTRAR DATE FEB 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...			

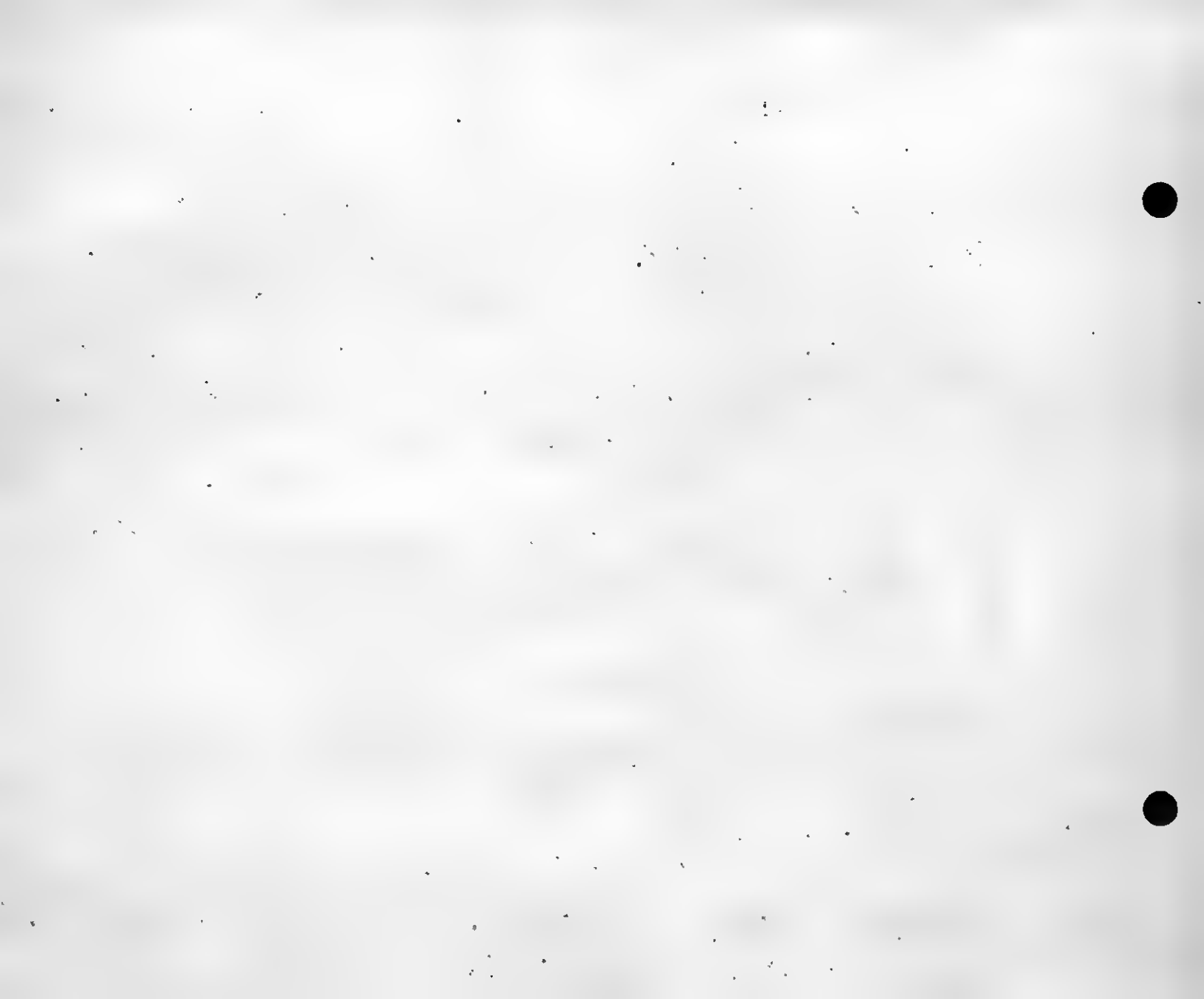
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) BLANCHE DOON HARRELL						2a. DATE OF DEATH Month 2 - Day 13 - Year 68			2b. HOUR 5:30 P.M.			
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH July 5, 1899			6 AGE (In years lost birthday) 68 YRS.		7 IF UNDER 1 YEAR MONTHS		7 IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester X Md.						
10. CITY OR TOWN OF DEATH Cambridge			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None listed			12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE md.			13b. COUNTY Talbot		13c. CITY OR TOWN St. Michaels		13d. INSIDE CITY - HTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER -			
14 FATHER'S NAME First Matthew Middle DOON Last DOON				15. MOTHER'S MAIDEN NAME First ANNA Middle Willen Last Willen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO Not listed			17 INFORMANT Address Eastern Shore State Hosp, Cambridge, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 17 (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH DAYS YEARS YEARS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) CHRONIC BRAIN SYNDROME												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 10:00 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 12-27-1967 to 2-13-1968 , that (I) (we) last saw the deceased alive on 2-13-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Leandro Area DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 2-13-68						
22d. PHYSICIAN'S NAME (Type) LEANDRO AREA M.D.						22e. ADDRESS EASTERN SHORES HOSP.-CAMBRIDGE MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 2/17/68		23c. NAME OF CEMETERY OR CREMATORY NANSEMOND CO.		23d. LOCATION (City or Town) (County) (State) SUFFOLK NANSEMOND VIR.						
24 FUNERAL DIRECTOR Friedrich C. DeLave ADDRESS CAMBRIDGE MD				25a. REC'D BY REGISTRAR FEB 16 1968		25b. REGISTRAR'S SIGNATURE Leandro Area						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print) Helen			First Clark Middle Hollerman Last			2a DATE KNOWN OF DEATH EST. MATED 2/21 19 68		2b HOUR 11P		
3 SEX Female	4 RACE White	5 DATE OF BIRTH 5/5/1895	6 AGE (in years last birthday) 72 YRS	F UNDER 1 YEAR MONTHS DAYS 		F UNDER 24 HRS HOURS MIN. 		2c DATE PRONOUNCED DEAD Month 2 Day 21 Year 1968		
7a BIRTHPLACE (State or foreign country) New Jersey		7b CIT. ZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester		Md		
10 CITY OR TOWN OF DEATH DOA Cambridge			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.			13b COUNTY Dor.		13c CITY OR TOWN E.N. Market		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER R F D	
14 FATHER'S NAME William			First Clark Middle Last			15 MOTHER'S MAIDEN NAME Jenny Sagan			First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give year or dates of service)			17 INFORMANT George E. Hollerman			ADDRESS East New Market, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Mins.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 4										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Pace Jr.			EXAMINER'S NAME (Type) John Pace Jr. M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 2/23/68		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 2/24/68		23c NAME OF CEMETERY OR CREMATORY East New Market Cem.			23d LOCATION (City or Town) (County) (State) E.N. Market Dor. Md.		
24. FUNERAL DIRECTOR Willoughby			ADDRESS East New Market Md.			25a REC'D BY REGISTRAR DATE FEB 27 1968		25b REGISTRAR'S SIGNATURE Charles J. Jones		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First CURTIS		Middle S.		Last HUBBARD		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>		2b HOUR ? M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH Aug. 17, 1917		6 AGE (In years last birthday) 50 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a BIRTHPLACE (State or foreign country) Maryland		7b CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester		2c DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>		2d HOUR 9 PM	
10 CITY OR TOWN OF DEATH Cambridge		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1405 Race Street		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Stock Clerk		12b KIND OF BUSINESS OR INDUSTRY Wire Cloth					
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md		13b COUNTY Dorchester		13c CITY OR TOWN Cambridge		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1405 Race Street			
14 FATHER'S NAME First John Middle ? Last Hubbard		15 MOTHER'S MAIDEN NAME First Daisy Middle ? Last Marshall									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war and dates of service) WW II		16b SOCIAL SECURITY NO. 220-10-6634		17 INFORMANT Mr. Fred Palmer, 501 Glodsbrough Ave		ADDRESS Cambridge Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 4109 DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Mace Jr.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/8/68					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Feb 9, 1968		23c NAME OF CEMETERY OR CREMATORY Spedden-Seward Cemetery		23d LOCATION (City or Town) (County) (State) RFD 3, Cambridge, Maryland					
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS		25a REC'D BY REGISTRAR DATE FEB 13 1968		25b REGISTRAR'S SIGNATURE					

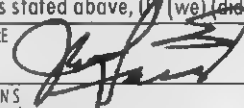




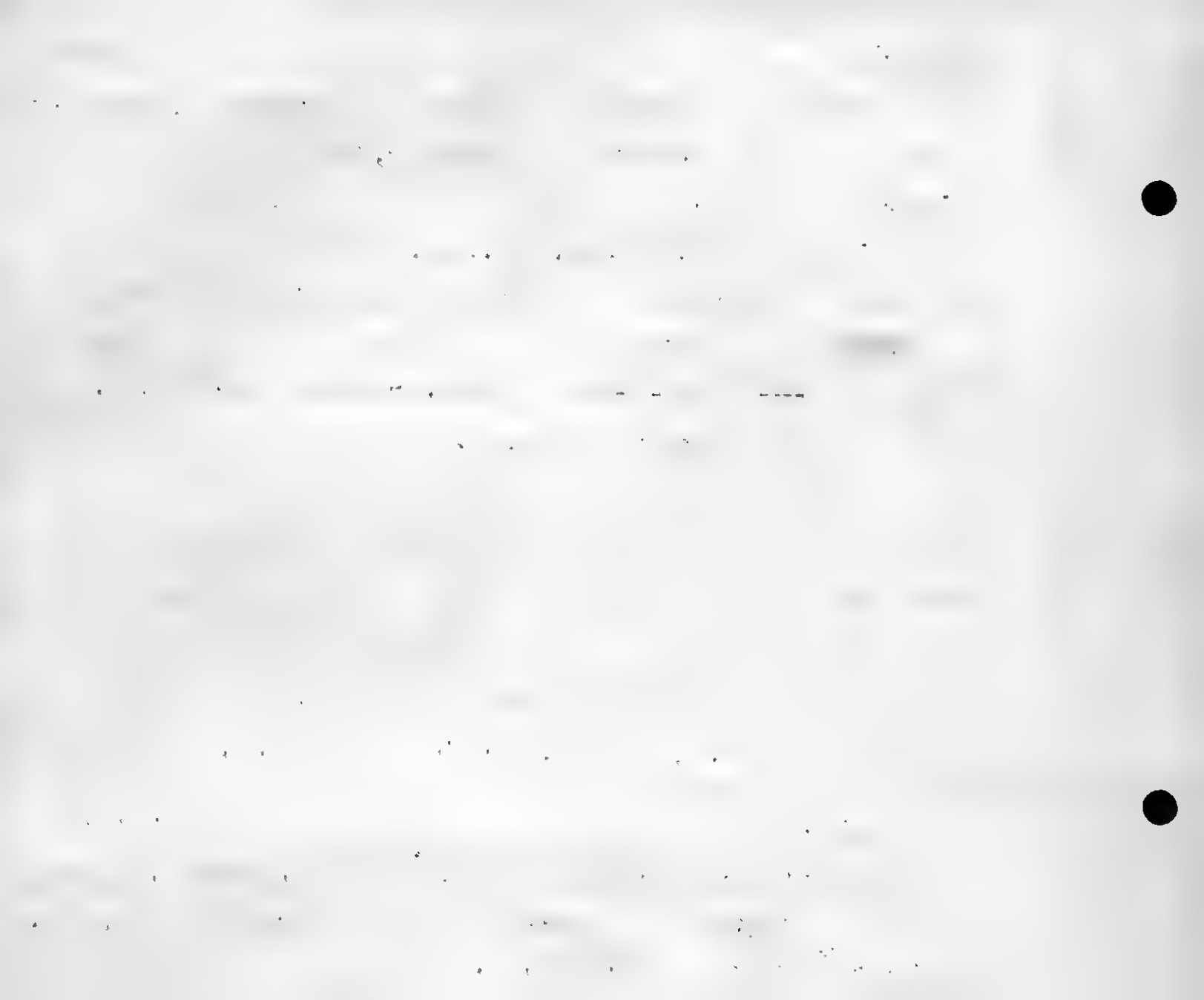
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
ALLEN				MILDRED	JENKINS	FEBRUARY 5, 1968			6:30AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		NEGROID		NOVEMBER 7, 1922		45 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				DORCHESTER Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CAMBRIDGE			CAMBRIDGE MD. HOSP., INC.			LABORER					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			DORCHESTER		CAMBRIDGE				701 LEONARDS LANE		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JAMES				HOLLAND		ETHEL				JENKINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			213-24-1780			ETHEL J. McCARTER			CAMBRIDGE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial endocarditis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 23, 1967</u> , to <u>Feb. 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb. 8, 1968	
22d. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D.						22e. ADDRESS 623 High Street, Cambridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
BURIAL			2/8/68		BETHEL		CAMBRIDGE		DOR.	MD.	
24. FUNERAL DIRECTOR 						ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

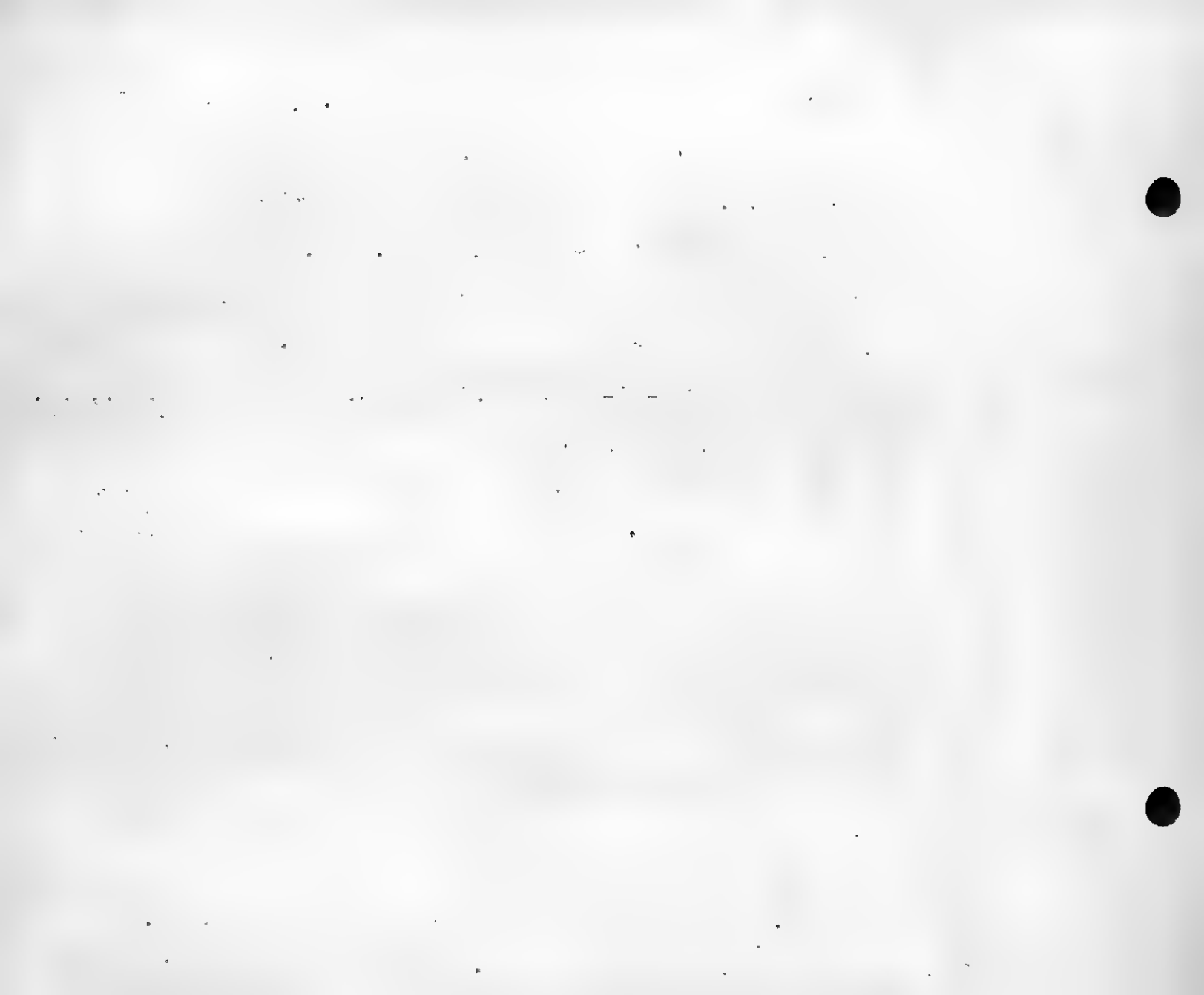
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Earl Johnson			2a. DATE OF DEATH Feb. 21 1968			2b. HOUR Noon			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 31, 1889		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Dorchester		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge-Maryland Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ret. Merchant		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 612 Race street	
14. FATHER'S NAME First Middle Last James Johnson			15. MOTHER'S MAIDEN NAME First Middle Last Jamesetta West						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 214-32-7433		17. INFORMANT Address Mrs. George R. Ruark, Trappe, Md., R.D.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerotic kidney DUE TO, OR AS A CONSEQUENCE OF (c) arterio-sclerotic heart								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown Unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 1967 , to Feb 21 1968 , that (I) (we) last saw the deceased alive on Feb 21 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. H. Thompson				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/24/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Md.			
24a. FUNERAL DIRECTOR Remeth A. Thorne				ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										23	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) First Middle Last Theodore Alvin Johnson						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 2/ 22 1968			2b. HOUR 5 PM		
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 2/18/68		6 AGE (in years last birthday) YRS MONTHS DAYS 4		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 2 22 19 68	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Dorchester Md.					
10 CITY OR TOWN OF DEATH Cambridge				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.				13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 620 Wells St.	
14. FATHER'S NAME First Middle Last Theodore Alvin Woolford Jr. Ola						15. MOTHER'S MAIDEN NAME First Middle Last Mae Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Ola Mae Johnson 620 Wells St. 21613					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peritonitis, perforation stomach</u> 5602 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Volvus with high intestinal obstruction</u> ? DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 570.3											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county) Cambridge, Md.				22b. DATE SIGNED 3/6/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/27/68		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION (City or Town) (County) (State) Cambridge Dor. Md.			
24. FUNERAL DIRECTOR Luther C. Blair						ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE MAR 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

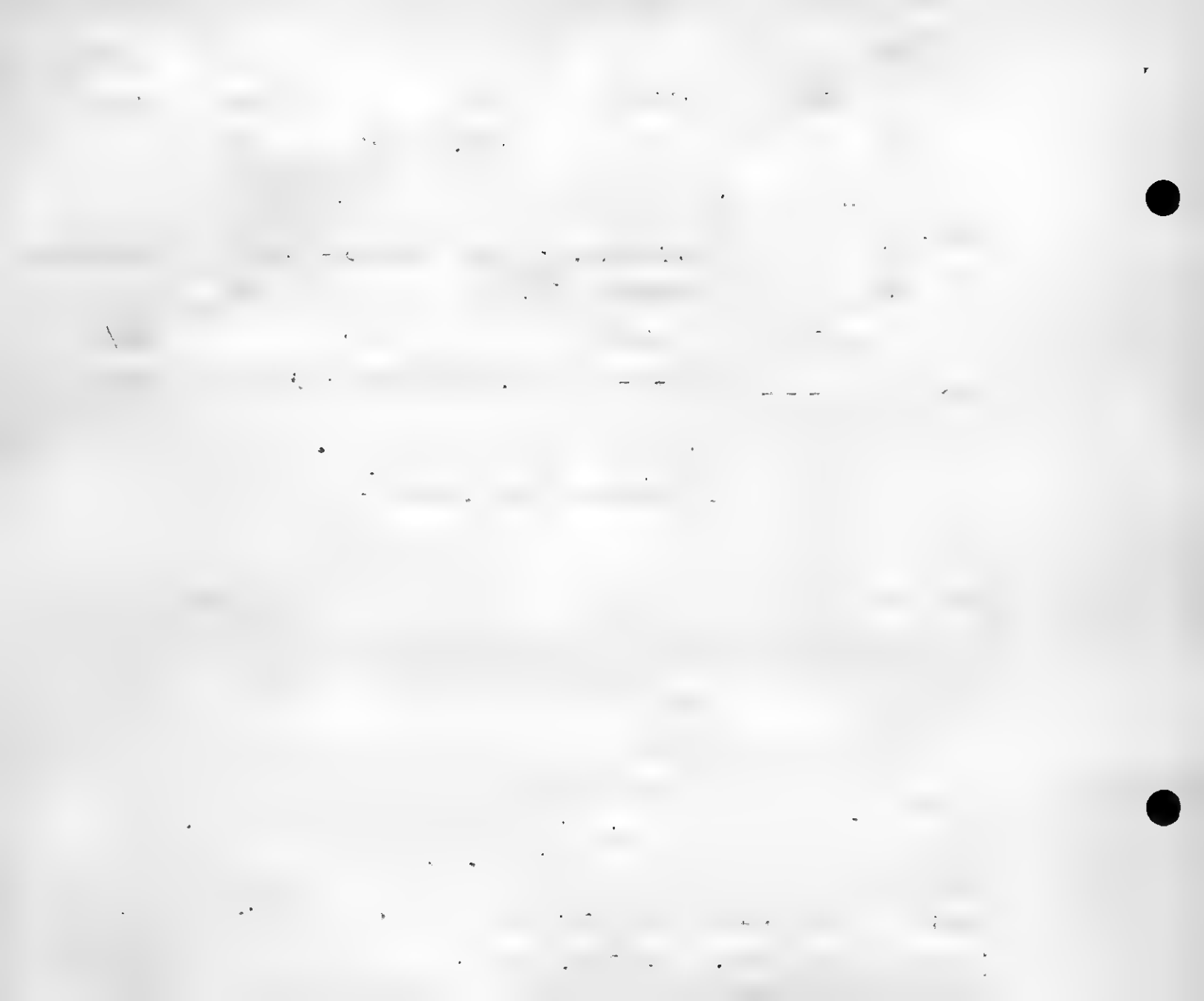
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) HENNIE WINGATE JONES			2a DATE OF DEATH Month Feb Day 4 Year 1968		2b HOUR 6 A M
3. SEX Female	4 RACE White	5 DATE OF BIRTH Sept. 6, 1913		6 AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seafood-Housewife		12b. KIND OF BUSINESS OR INDUSTRY Seafood Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Md	13b. COUNTY Dorchester	13c. CITY OR TOWN Bishops Head	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None	
14. FATHER'S NAME First Lemuel Middle Wingate Last Wingate		15. MOTHER'S MAIDEN NAME First Cora Middle Todd Last Todd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) - - -		16b. SOCIAL SECURITY NO. 212-18-6670		17. INFORMANT Mr. Henry Jones, Bishops Head, Maryland Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) Phlebotomy of R.V. by DUE TO, OR AS A CONSEQUENCE OF (c) last. Cand trans, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 463x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John W. Kiehn, Pathologist				22c. DATE SIGNED 2-5-68	
22d. PHYSICIAN'S NAME (Type) Peter W. Rieckert				22e. ADDRESS E-New Market, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 6, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	
23d. LOCATION (City or Town) Cambridge, Maryland		(County) Dorchester		(State) Md	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland ADDRESS				25a. REC'D BY REGISTRAR DATE FEB 7 1968	
25b. REGISTRAR'S SIGNATURE Charles Jones					

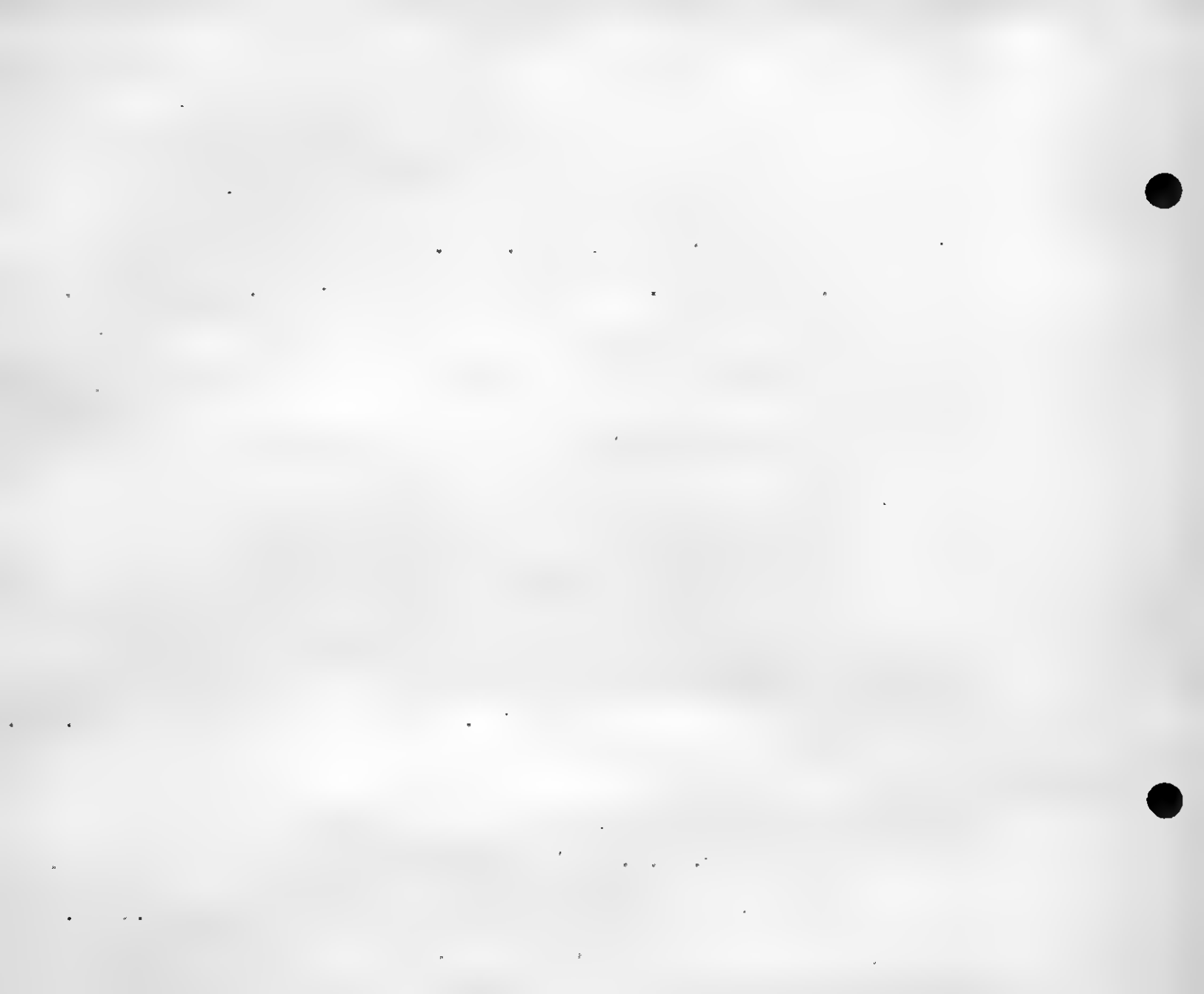


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR
Brian David Kerrick						ESTIMATED 2/6			2/6		1968	AM
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (in years at birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	11/8/1967	YRS 2	MONTHS 28	HOURS	MIN	Month 2 Day 6 Year 1968			3:30 AM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH				
Md.		USA		WIDOWED		DIVORCED		Dorchester				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge			DOA Cambridge Md. Hosp.			None			None			
13a. USUAL RESIDENCE (Where deceased lived, if not in institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.			Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		317 E. Appleby Ave.			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last	
Bernard					Kerrick	Lynn					Morgan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			
No			None			Hospital Records			Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u>											?	
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			5 AM 2/6/68			Beaten by father						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			
			Home			317 E. Appleby Ave			Cambridge, Dor. Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Noturo causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS STANT MED CAL EXAMINER			22b. DATE SIGNED			
<i>John Mace Jr.</i>									2/7/68			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)						
John Mace Jr. M.D.			<input checked="" type="checkbox"/>			Cambridge, Md.						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial		2/8/68		McKendree Cemetery			Rhodesdale, Dor., Md.					
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Widloughby				East New Market, Md.				DATE FEB 13 1968		<i>Charles J. ...</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										02544
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Jerusha L. Lowe						2 Month 17 Day 1968			M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		White		10/20/1881		88 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Dorchester Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge			Cambridge-Maryland			Housework				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Dorchester		Cambridge YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
James Hurley			Jane (Unkn)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
no			213-01-2434		Mrs. Marie L. Hastings,			Cambridge, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a)										9 days
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										16 yrs
(b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Stenosis, urinary calculi, Diabetes mellitus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										State
22a. I certify that (I) (this hospital) attended the deceased from 2/8/68, 19 to 2/17, 1968, that (I) (we) last saw the deceased alive on 2/17/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
Lawrence Maryanov M.D.		2/20/68		Lawrence Maryanov		610 Race St, Cambridge, Md				
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Buried		2/20/1968		East New Market		East New Market, Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NEWMAN FUNERAL HOME, Sharptown, Md.						DATE FEB 23 1968		Charles J. J...		

FOR STATE HEALTH DEPT.

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Item 21 Film 398
3-12-68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
MARGARET FEAR McKENNA					ESTIMATED		2-29		1968	4:15 PM
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
Female	White	10-13-85		82 YRS	MONTHS	DAYS	HOURS	MIN	Month	Day
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
MARYLAND		U.S.A.				Dorchester X Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cambridge		Eastern Shore State Hosp				HAIR DRESSER		—		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland		CAROLINE		DENTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3rd Street		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
BOSTON				FEAR	LACKNER, Elizabeth				FEAR	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
NO		Not listed		EASTERN SHORE STATE HOSP. (Med. Records)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary Embolism										6 Hours
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										1 month
(b) Ex (D) femur										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
904.0 None										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. 2 P.M. 1/26 19 68		Fell in home						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State
		Home						Caroline		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED
John Mace Jr		JOHN MACE JR		M.D.				2/29/68		
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		MAR 3, 1968		CONCORD		CONCORD		CAR.		MD.
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REG STRAR		25b REG. STRAR'S SIGNATURE		
J. Virgil Moore & Son				Denton Md		DATE MAR 5 1968		Charles Judge		

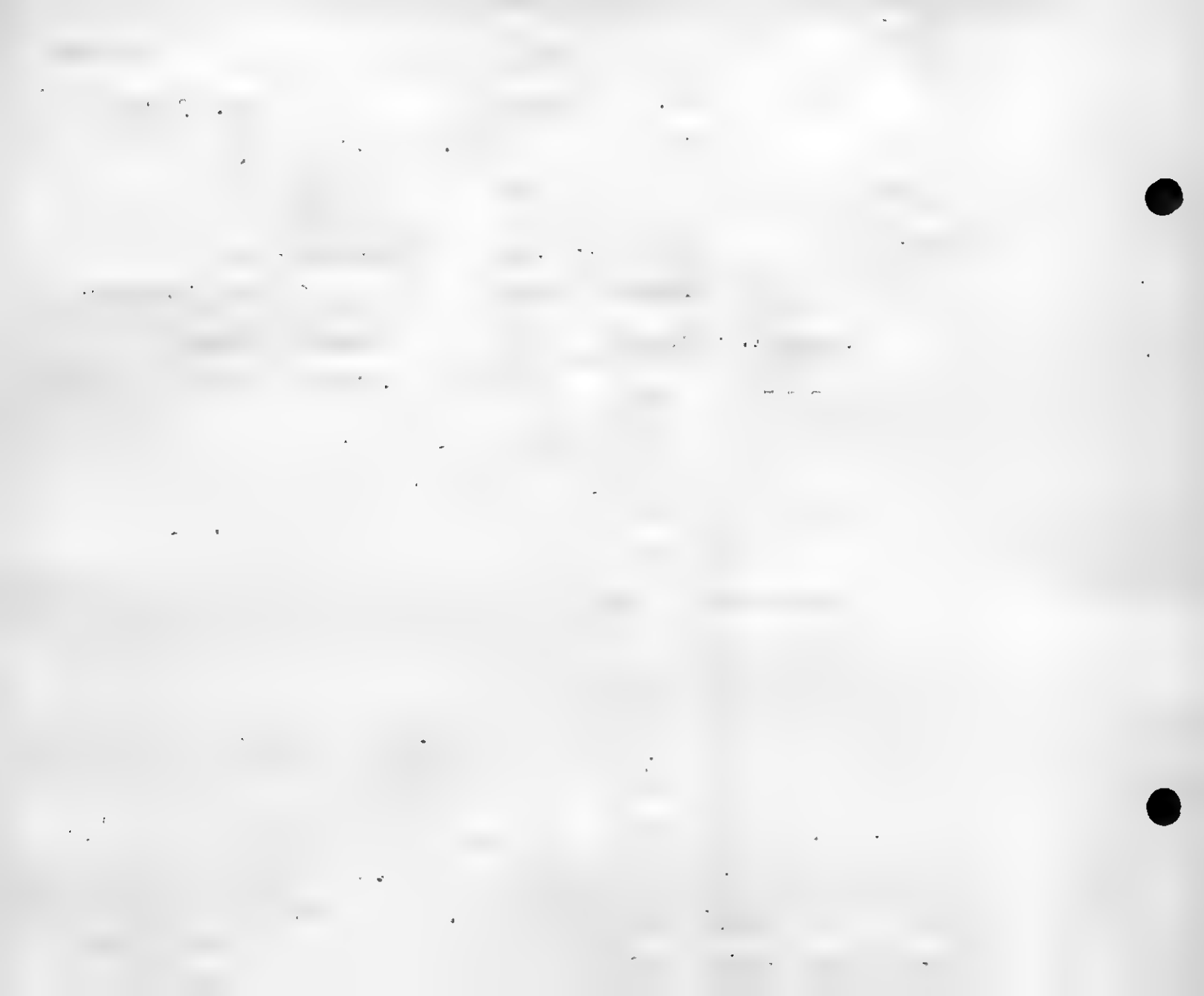
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) FRANK G. MEEKINS			2a DATE OF DEATH Month Feb. Day 23 Year 1968			2b HOUR 11 A			
3 SEX Male		4 RACE White		5 DATE OF BIRTH Sept. 23, 1886		6 AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester			
10 CITY OR TOWN OF DEATH Cambridge		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 218 West End Avenue		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bookkeeper-Ret		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 218 West End Avenue	
14. FATHER'S NAME First Middle Last Richard T. F. Meekins			15 MOTHER'S MAIDEN NAME First Middle Last Cornelia Andrews						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. unk		17. INFORMANT Address Mrs. Frank G. Meekins, Cambridge, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Coronary Insufficiency (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Idem									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/6/67 , 19 67 , to 2/24/68 , 19 68 , that (I) (we) last saw the deceased alive on 2/20/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence Maryanov MD		22c. DATE SIGNED 2/24/68		22d. PHYSICIAN'S NAME (Type) Lawrence Maryanov		22e. ADDRESS 610 Ridge St Cambridge, Md. 21613			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE Feb 25, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR FEB 29 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

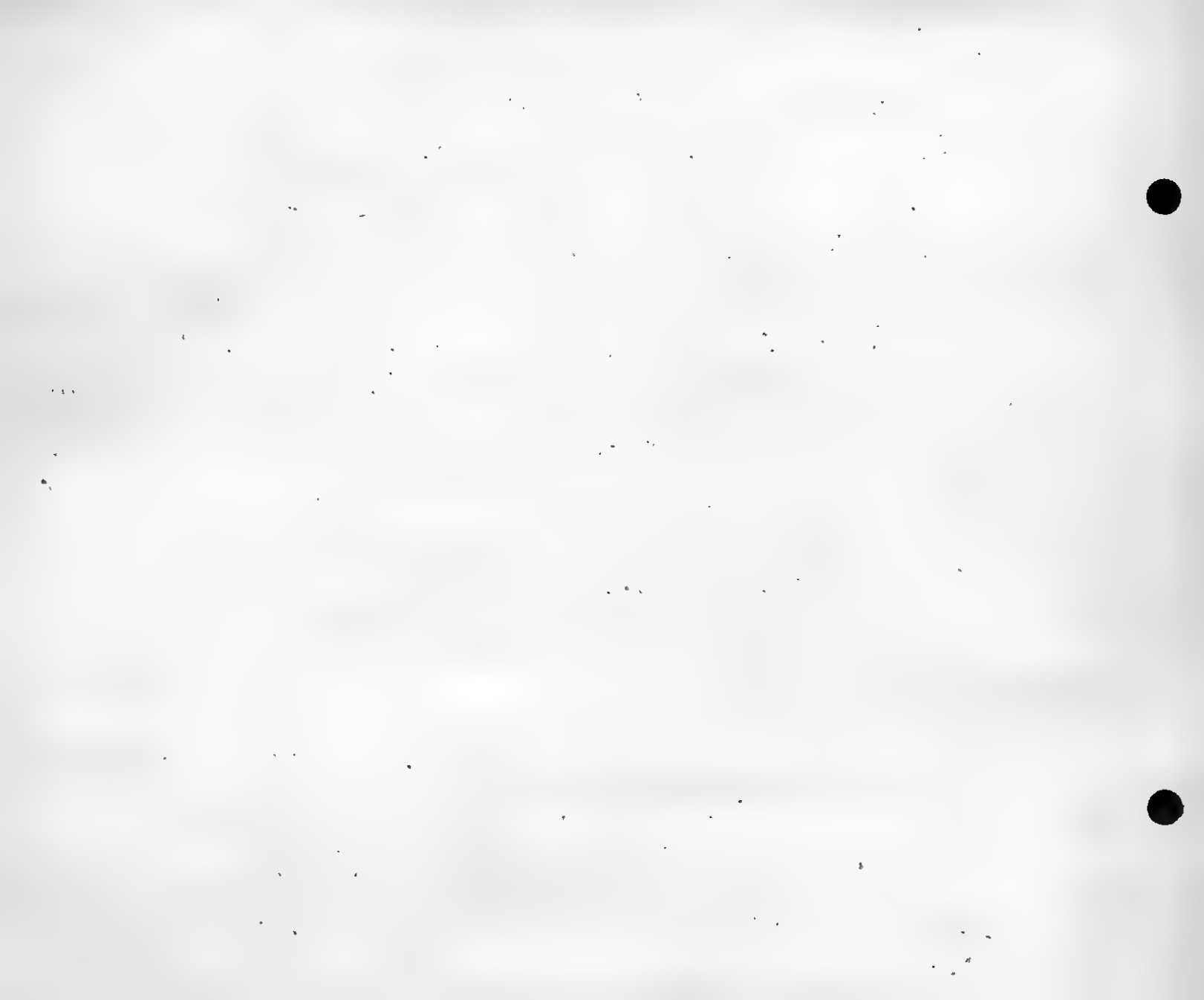


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

561
Item 6 Film G398 2/29/68 kdc
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

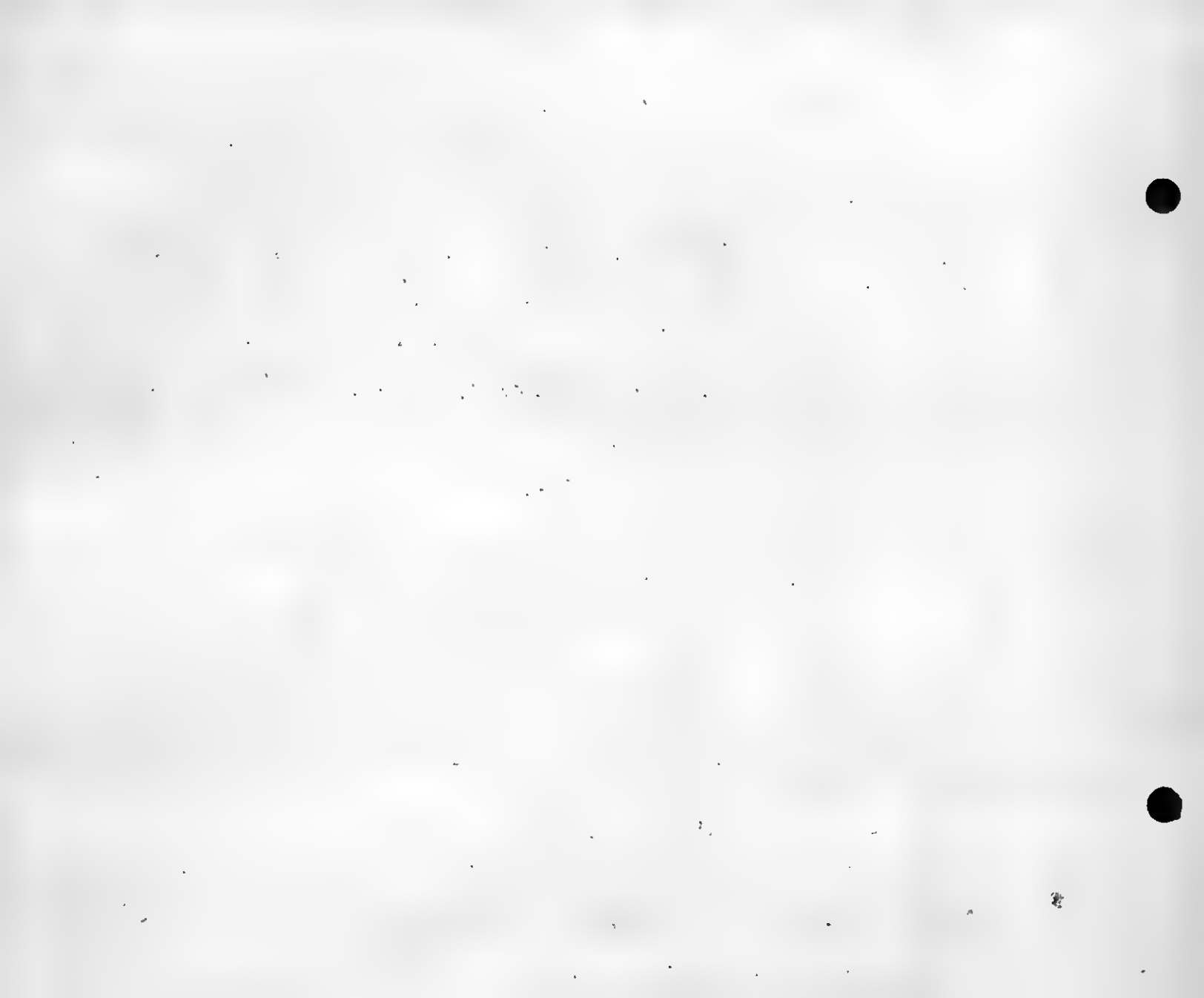
1. DECEASED-NAME (Type or print) First Middle Last MARGARET C. Neal			2a. DATE OF DEATH 2 Month 17 Day 68 Year		2b. HOUR 2A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4-27-01		6. AGE (In years last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eastern Shore State		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY Caroline	13c. CITY OR TOWN Denton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. 2 Box 23B Denton Md	
14. FATHER'S NAME First Middle Last Edward W. Neal		15. MOTHER'S MAIDEN NAME First Middle Last Louara Anderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO -		17. INFORMANT Address Eastern Shore State - Camb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS-A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS-A CONSEQUENCE OF (c) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4500					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Brain Syndrome					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that ED (this hospital) attended the deceased from May 8, 1965 , to Feb 17, 1968 , that (I) (me) last saw the deceased alive on Feb 17, 1968 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (me) (did) (did not) view the body after death.					
22b. SIGNATURE Edwards - MD		22c. DATE SIGNED 2-17-68		22d. PHYSICIAN'S NAME (Type) EDWARD LEWIS - ESSH, Cambridge, Md -	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Denton	
23d. LOCATION (City or Town) (County) (State) DENTON MD		24. FUNERAL DIRECTOR Charles W. Keene Denton Md		25a. REC'D BY REGISTRAR FEB 26 1968	
25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR							
HORATIO R. NELSON						FEB 24 68			9 10 AM							
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS. HOURS MIN.					
MALE		WHITE		7-25-88			19 YRS									
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH							
PHILADELPHIA PA.			U.S.A.						DORCHESTER			MD				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY							
CAMBRIDGE			EASTERN SHORE STATE HOSP.			SALESMAN			SALESMAN							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
ROYAL OAK			TALBOT			ROYAL OAK										
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MA DEN NAME			First	Middle	Last					
HORATIO					NELSON	MINERVA ROOKEY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			Address							
NO			25-07-1835			EASTERN SHORE STATE HOSP.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA											1 WK					
DUE TO, OR AS A CONSEQUENCE OF (b) PYLONEPHRITIS											1 MO.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
SEVERE CACHEXIA																
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f LOCATION			Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from FEB 21, 1968, to FEB 24, 1968, that (I) (we) lost saw the deceased alive on FEB 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE Sean M. Killoran M.D.						DEGREE M.D.			MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Feb 24, 1968				
22d PHYSICIAN'S NAME (Type)						SEAN M. KILLORAN M.D.			22e ADDRESS 7415 BLAIR RD, WASHINGTON, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)							
Burial			Feb 28, 1968			Mt. Moriah Cemetery			Philadelphia Pennsylvania							
24. FUNERAL DIRECTOR						ADDRESS			25a REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE				
J. J. Conner						St. Michaels			FEB 28 1968			J. J. Conner				

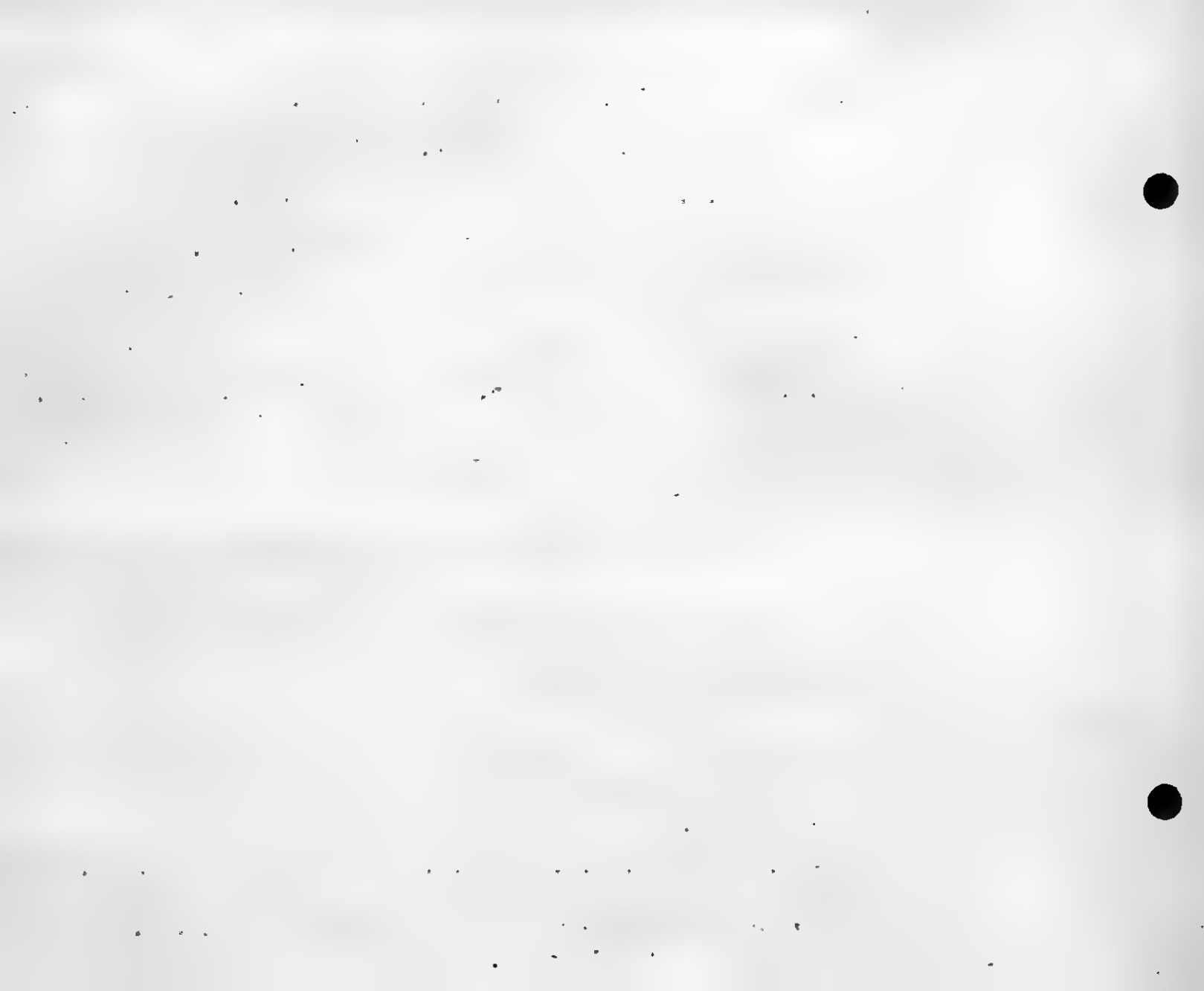


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

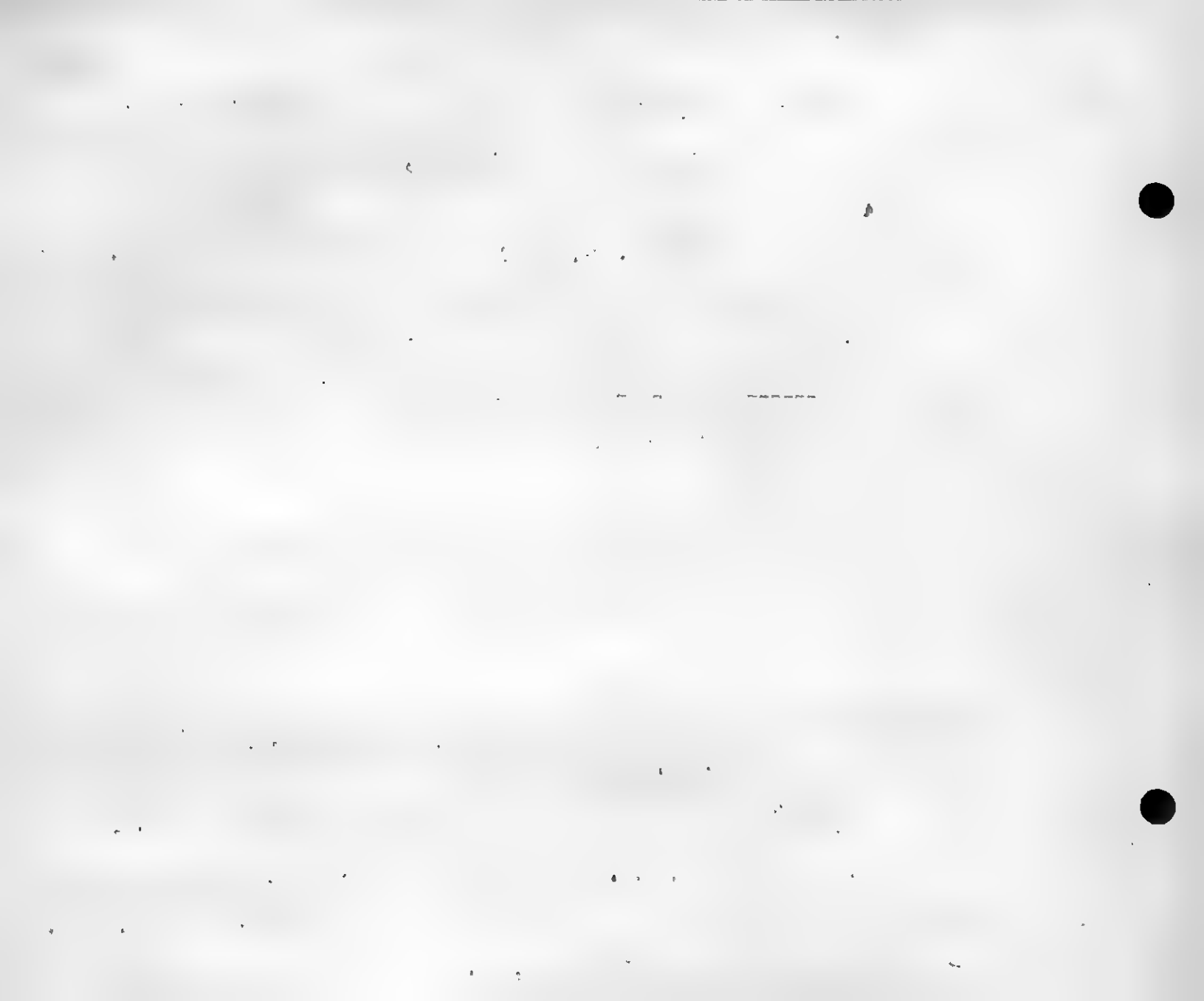
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
02563										
02549										
1. DECEASED-NAME (Type or print)			First Middle Last Gerry William Phillips			2a. DATE OF DEATH Feb. Month 17 Day 1968 Year		2b. HOUR 6:15		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 26, 1886		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.				
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 214 Willis Street			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Merchant Ret.		12b. KIND OF BUSINESS OR INDUSTRY Grocer		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 214 Willis Street	
14. FATHER'S NAME First Middle Last Benjamin Phillips			15. MOTHER'S MAIDEN NAME First Middle Last Clara Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT Address 214 Willis St., Mrs. Beulah E. Phillips, Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4107 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS		
								YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7-2-1										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 11-7-66, 19, to 2-17, 1968, that (1) (we) last saw the deceased alive on 1-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James F. McCarter					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-17-68			
22d. PHYSICIAN'S NAME (Type) James F. McCarter, M.D.					22e. ADDRESS P.O. Box 386 Cambridge, Md. 2161					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Feb. 19, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park Cemetery, Md.		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR James A. Shoups		ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE FEB 21 1968		25b. REGISTRAR'S SIGNATURE James A. Shoups				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
02550									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M
ROBERT CLINTON REESE						FEBRUARY 10 1968			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		NEGRO ID		MARCH 5, 1909			58 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
VIRGINIA		USA					DORCHESTER Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
CAMBRIDGE			CAMBRIDGE MD. HOSPITAL			LABORER			OYS. SHUCKER
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			DORCHESTER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		610 WELLS STREET		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
CHARLES REESE			MAGGIE REESE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
NO			214-10-0791		ANNIE REESE 610 WELLS STREET 21613				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
					10				
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1968 to February 19, 1968, that (I) (we) last saw the deceased alive on Feb. 10, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb. 10, 1968	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
J. EDWIN FASSETT, M.D.			623 High Street, Cambridge, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/14/68		MADISON		MADISON DOR. MD.			
24. FUNERAL DIRECTOR			ADDRESS			25a. RECD BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
J. Edwin C. Blair			CAMBRIDGE, MD.			FEB 14 1968			



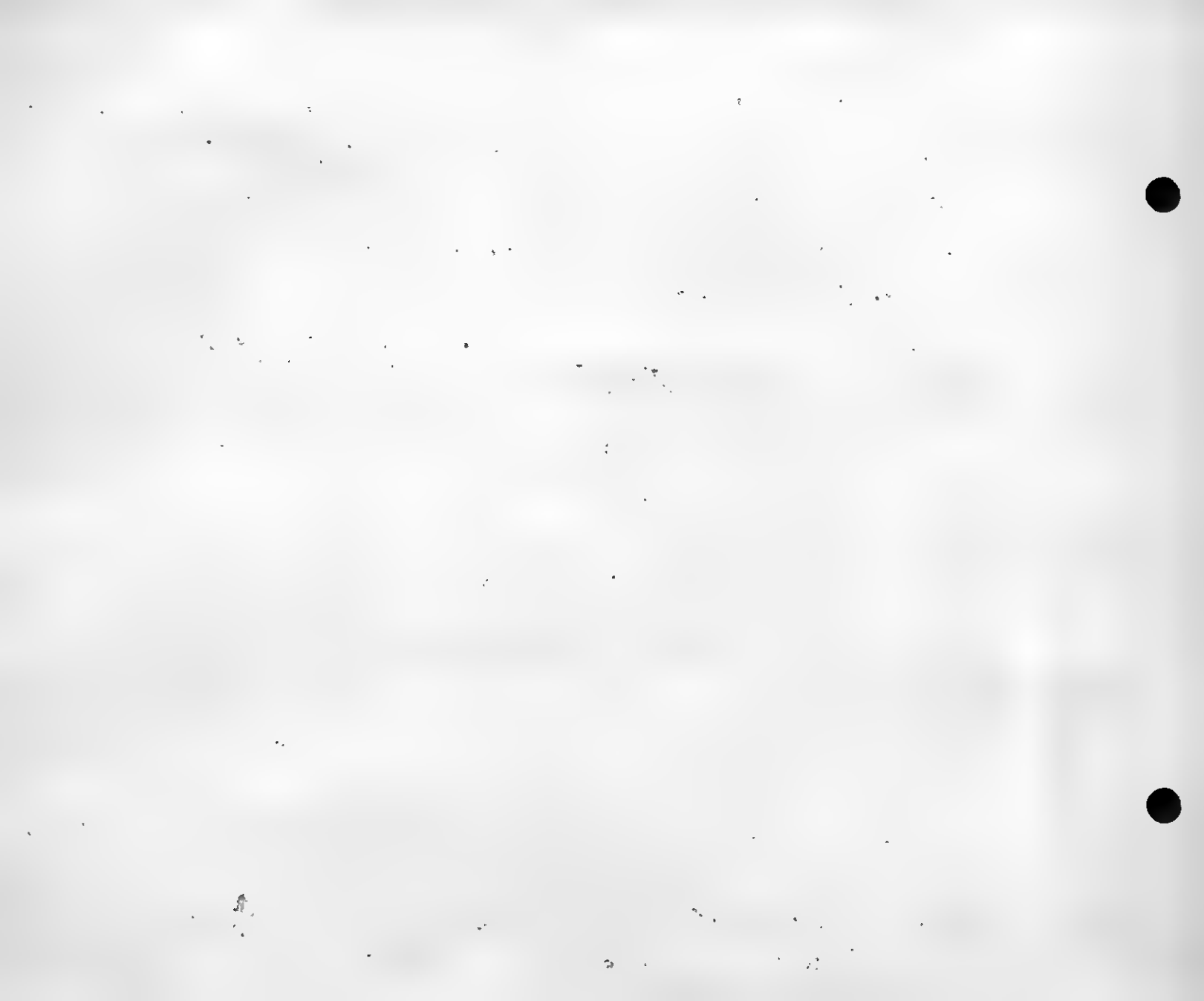
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
02551													
1. DECEASED NAME (Type or print) Lula May Salisbury						2a. DATE OF DEATH Month Feb. Day 10 Year 1968			2b. HOUR 11:30 P.M.				
3 SEX Female		4 RACE White		5 DATE OF BIRTH 06-05-1887			6 AGE (in years) last birthday 80 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester							
10. CITY OR TOWN OF DEATH Rural Cambridge				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Eastern Shore State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.				13b. COUNTY Tal		13c. CITY OR TOWN Trappe		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14 FATHER'S NAME First Adam Middle Bryan Last Bryan				15. MOTHER'S MAIDEN NAME First SARAH Middle LYONS Last LYONS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown)				16b. SOCIAL SECURITY NO. 238-34-7548				INFORMANT Med. Records Address Eastern Shore State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: 4341													
(b) PNEUMONIA													
DUE TO, OR AS A CONSEQUENCE OF													
(c) 1													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) DEHYDRATION + CHRONIC BRAIN SYNDROME													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from FEB 9 , 1968, to FEB 10 , 1968, that (I) (we) last saw the deceased alive on FEB 10 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Sean M. Killoran M.D.								22c. DATE SIGNED FEB 10, 1968		22d. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN			
22e. ADDRESS 7415 BLAIR RD WASHINGTON, D.C.													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 2/13/1968		23c. NAME OF CEMETERY OR CREMATORY UPPER BANBURY			23d. LOCATION (City or Town) (County) (State) TRAPPE, MD				
24. FUNERAL DIRECTOR Funeral F. Newman-Joy								ADDRESS Eastern Shore		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

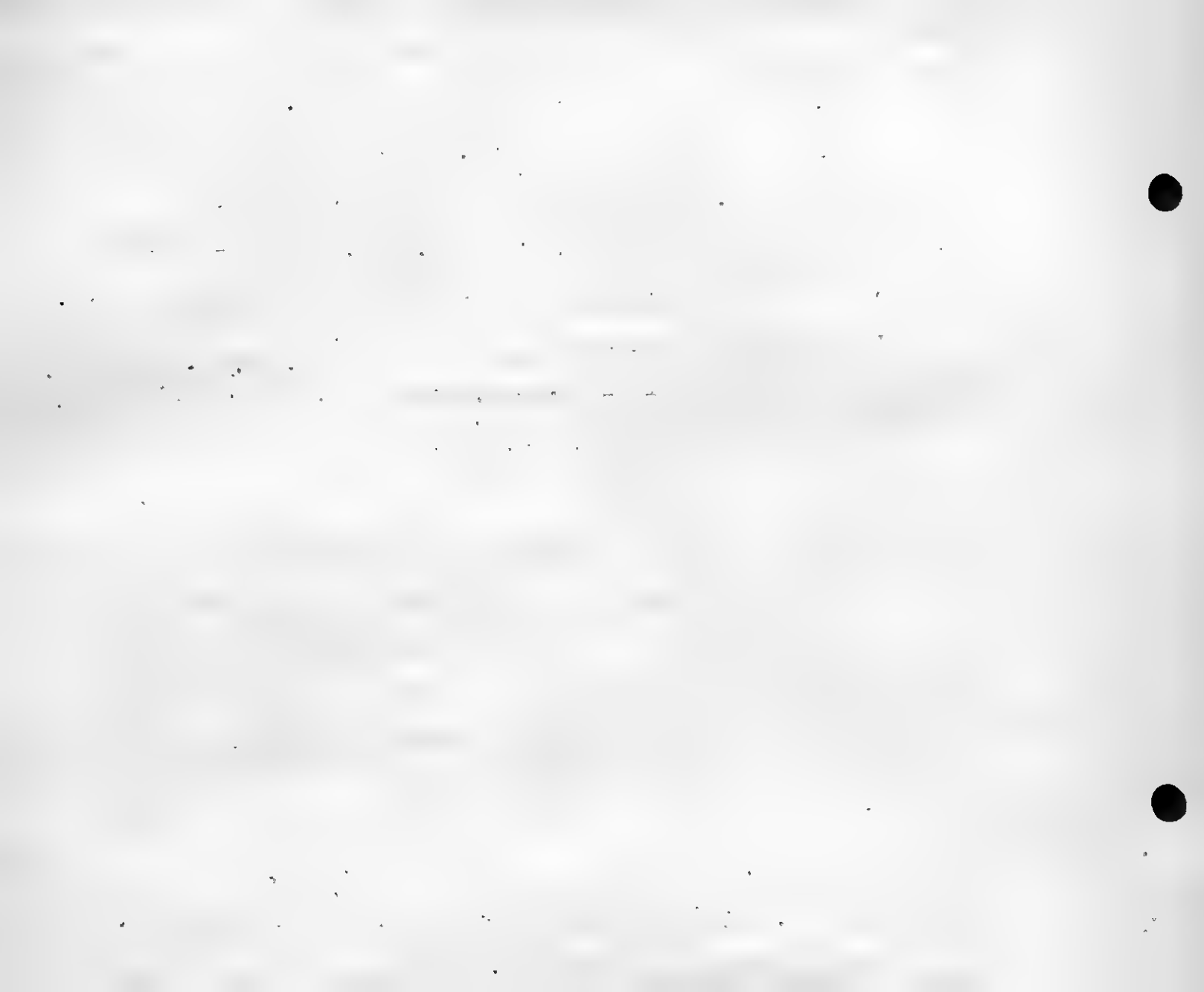
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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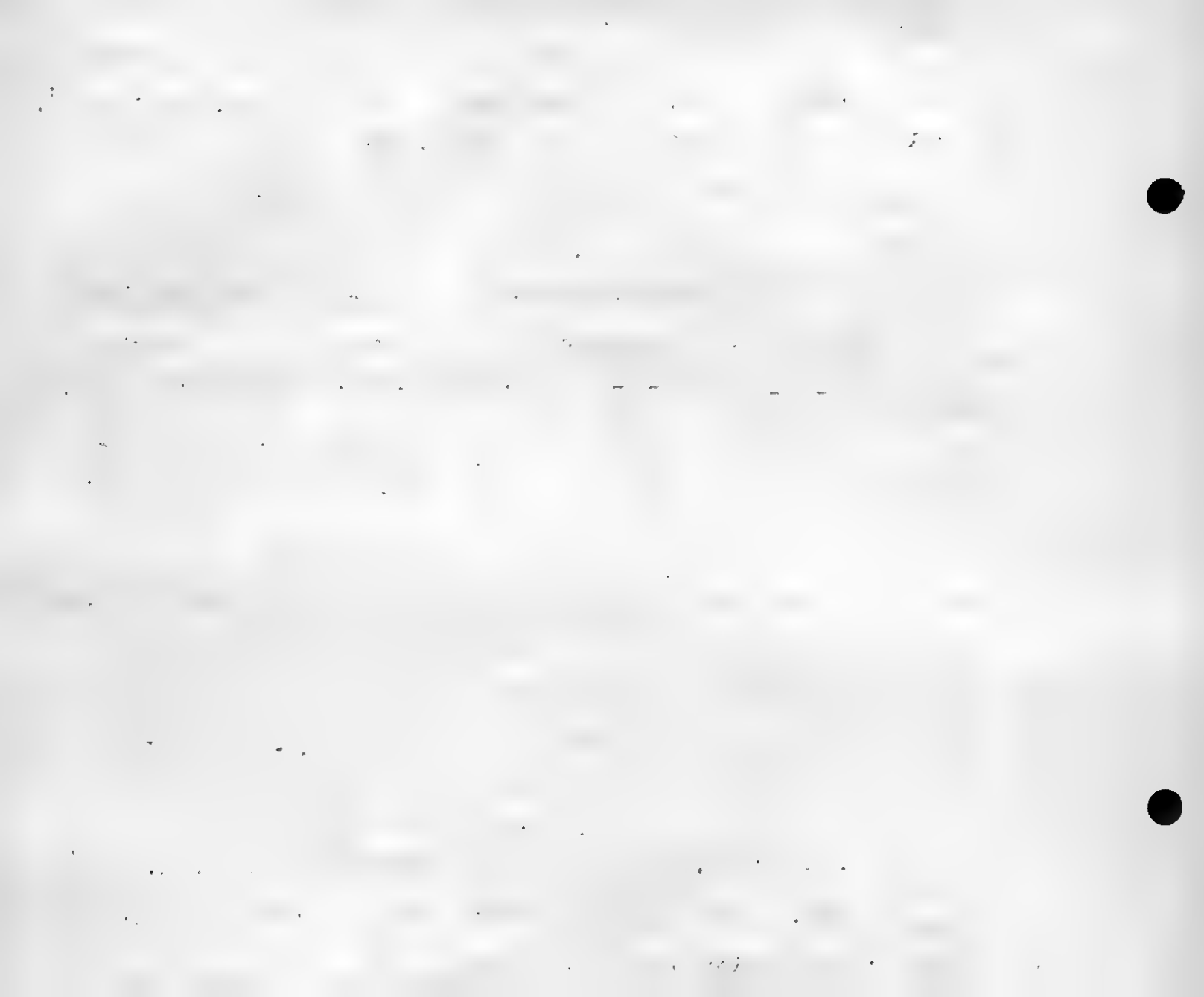
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) William Bedford Shannahan						2a. DATE OF DEATH Feb. Month 28 Day 1968		2b. HOUR 1:45	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 24, 1905		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Dorchester		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester Md.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 107 Dorchester Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Salesman-Driver		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 107 Dorchester Ave.	
14. FATHER'S NAME First Middle Last John William Shannahan				15. MOTHER'S MAIDEN NAME First Middle Last Bessie Curry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-07-7079		17. INFORMANT Mrs. Jeanette C. Shannahan, Cambridge.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Wilson's Disease DUE TO, OR AS A CONSEQUENCE OF (c) Years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) X Anemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 27, 1968 , to Feb 28, 1968 , that (I) (we) last saw the deceased alive on Feb 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/29/68			
22d. PHYSICIAN'S NAME (Type) [Signature]				22e. ADDRESS Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar. 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Md.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR [Signature]				ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR MAR 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 8 Film G398 3/19/68 kk										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
ROGER W. SHOEMAKER						Month Day Year Feb. 28 1968		8:15 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
Male		White		May 8, 1910		57 YRS.		MONTHS DAYS HOURS M.N.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Canada		USA				Dorchester Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			Cambridge Md. Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md			Dorchester		Cambridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1500 Hambrooks Blvd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Clyde ? Shoemaker			Bess ? Vivian							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? No			16b. SOCIAL SECURITY NO. 100-20-8240		17. INFORMANT Address Mr. David Glover, 1500 Hambrooks, Cambridge Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Coronary infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Coronary sclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>2-11-</u> 19 <u>65</u> , to <u>2-28</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W. N. Baumann</u>					22c. DATE SIGNED <u>3-1-68</u>					
22d. PHYSICIAN'S NAME (Type) W. N. Baumann, MD					22e. ADDRESS 10 Aurora St., Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Mar. 1, 1968		Dorchester Memorial Park		Cambridge, Maryland				
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland					25a. REC'D BY REGISTRAR DATE MAR 5 1968		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

02554

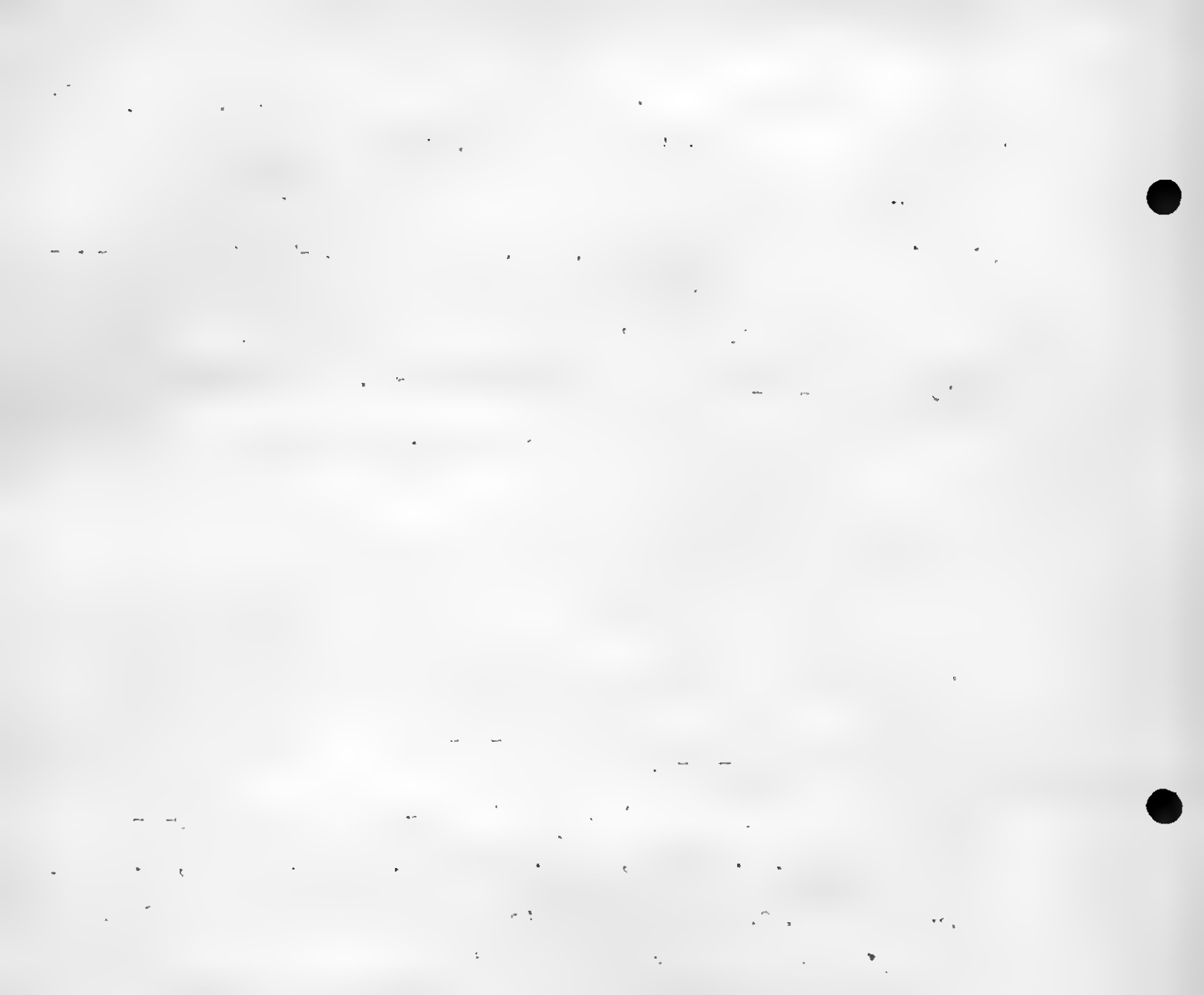
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR							
MARTIN		SPICER		FEBRUARY 3, 1968		12:05A											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
MALE		NEGROID		JANUARY 18, 1892		76 YRS		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
MARYLAND		USA				DORCHESTER											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
CAMBRIDGE		CAMBRIDGE MD. HOSP., INC.		LABORER													
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
MARYLAND		DORCHESTER		CAMBRIDGE				605 CEDAR STREET									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last							
FORTUNE		SPICER		JULIE		SPICER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address											
YES		WW I		212-40-7585		DOROTHY SPICER		605 CEDAR STREET		21613							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>Feb. 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED											
22d. PHYSICIAN'S NAME (Type)		J. EDWIN FASSETT, M.D.		22e. ADDRESS		623 HIGH STREET, CAMBRIDGE, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)											
BURIAL		2/6/68		BETHEL		CAMBRIDGE DOR. MD.											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Arthur C. Blair		CAMBRIDGE, MD.		FEB 13 1968		F. J. Blair											



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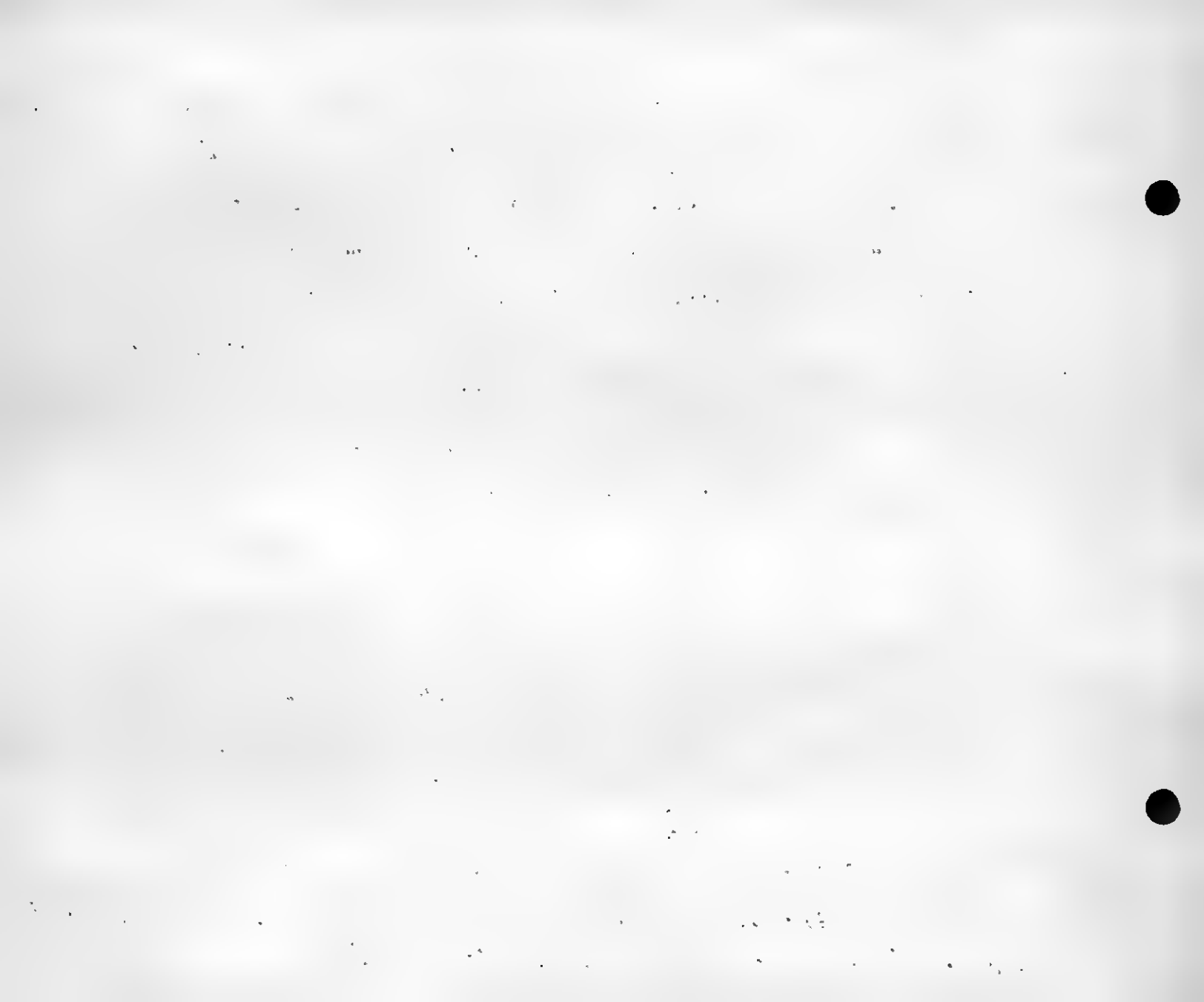
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) CHARLES S. TODD			2a. DATE OF DEATH Month Feb. Day 28 Year 1968			2b. HOUR 8:10 P. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 15, 1914		6. AGE (in years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Md. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Waterman-Retired		12b. KIND OF BUSINESS OR INDUSTRY - - -			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 404 High Street	
14. FATHER'S NAME First Ray Middle C. Last Todd			15. MOTHER'S MAIDEN NAME First Rena Middle Parks Last ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Mrs. Charles S. Todd, Cambridge, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER 185x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Sclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1110 Multiple Sclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-20-67 , 19__, to 2-28-68 , 19__, that (I) (we) last saw the deceased alive on 2-28-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Albert E. Bunker, M.D.</i>				22c. DATE SIGNED 3-1-68		22d. ADDRESS 200 Md. Ave., Cambridge, Md. 21613			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR DATE MAR 5 1968		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>			



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1. DECEASED-NAME (Type or print)		First MILDRED		Last LLOYD		Middle TRAVERS		20. DATE OF DEATH Month FEBRUARY 26, 1968		Day 7		Year 1968		2b. HOUR 7:50AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8/6/94				6. AGE (In years lost birthday) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH DORCHESTER Md.									
10. CITY OR TOWN OF DEATH RURAL CAMBRIDGE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) EASTERN SHORE STATE HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY DOR.		13c. CITY OR TOWN VIENNA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Middle							
14. FATHER'S NAME First BILLY LLOYD				Middle Last				15. MOTHER'S MAIDEN NAME First BERTIE Middle (unknown) Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 219-05-0367A		17. INFORMANT HOSPITAL RECORDS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM, MASSIVE, RIGHT</u> <u>1517</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>PHLEBOTHROMBOSIS, LEFT</u> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>66</u> , to <u>2/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/25/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>G. W. Rieckert</u>														22c. DATE SIGNED 2-26-68	
22d. PHYSICIAN'S NAME (Type) PETER W. RIECKERT, PATHOLOGIST														22e. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVING BODY		23b. DATE 2/28/68		23c. NAME OF CEMETERY OR CREMATORY Dor. Memorial Park				23d. LOCATION (City or Town) Cambridge		(County) Dor		(State) Md			
24. FUNERAL DIRECTOR <u>Buch S. Shilloughby, East New Market</u>				ADDRESS				25a. REC'D BY REGISTRAR DATE FEB 29 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Yague</u>					



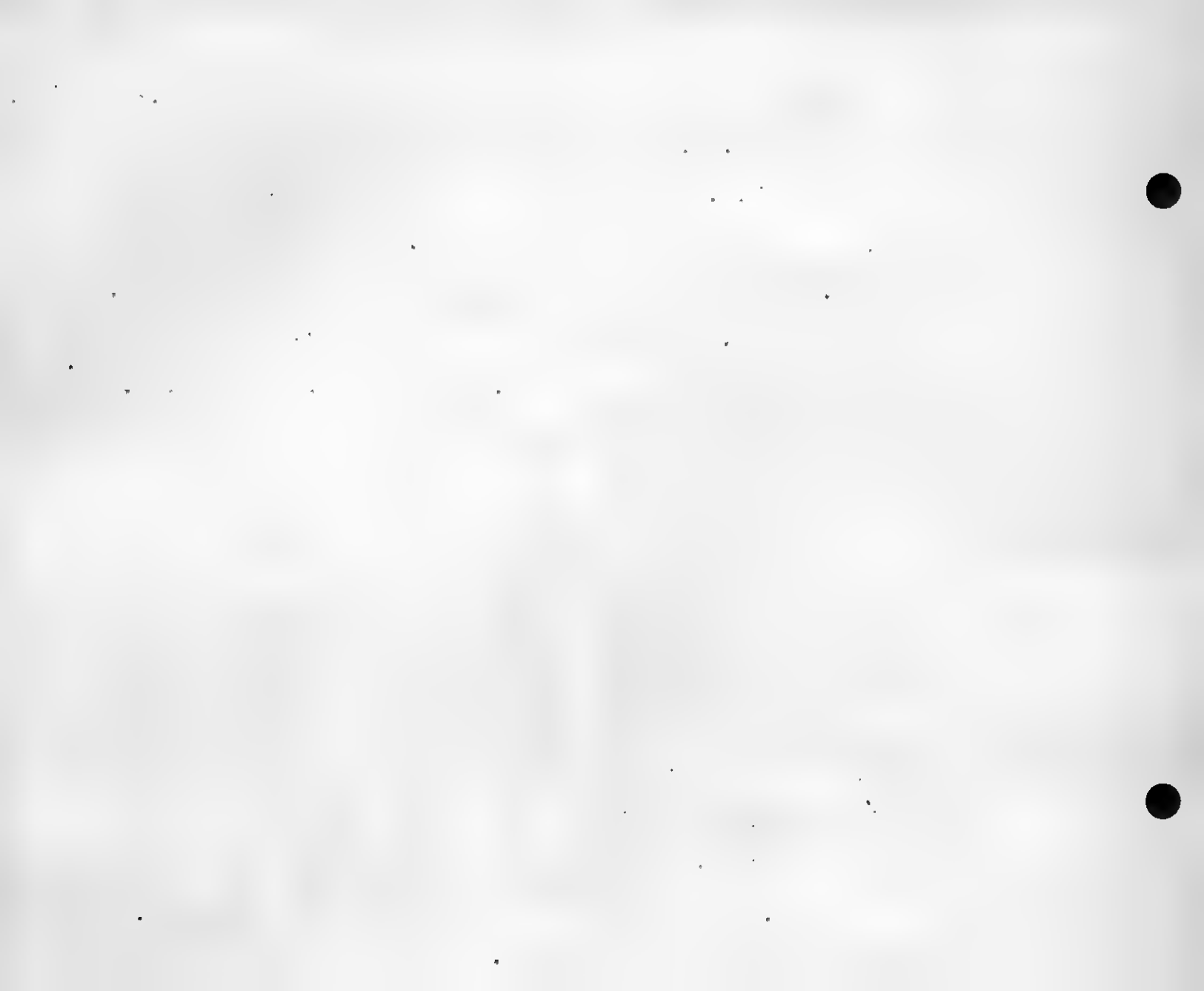
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Mattie May Wallace						Feb. 2 1968		6 P.M.		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		
Female	White	Aug. 20, 1883	84 YRS					Month Day Year 19		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Dorchester		U.S.				Dorchester Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			724 Glasgow St.			Homemaker				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Dorchester		Cambridge		YES		724 Glasgow St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William L. Wheatley			Amanda Marshall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No					410 Maryland Ave. Mrs. Edmund Burns, Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Coronary Occlusion									Instant	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
420										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held on			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
Actual Signature			M.D.							
EXAMINER'S NAME (Type)			22b. DATE SIGNED							
John Mace Jr. M.D.			2/3/68							
			ADDRESS (Street, city, town, or county) Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 4, 1968		Green Lawn Cemetery			Cambridge, Md.			
24. FUNERAL DIRECTOR				ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Kenneth P. Thomas				Cambridge, Md.			DATE FEB 6 1968		Charles Judge	

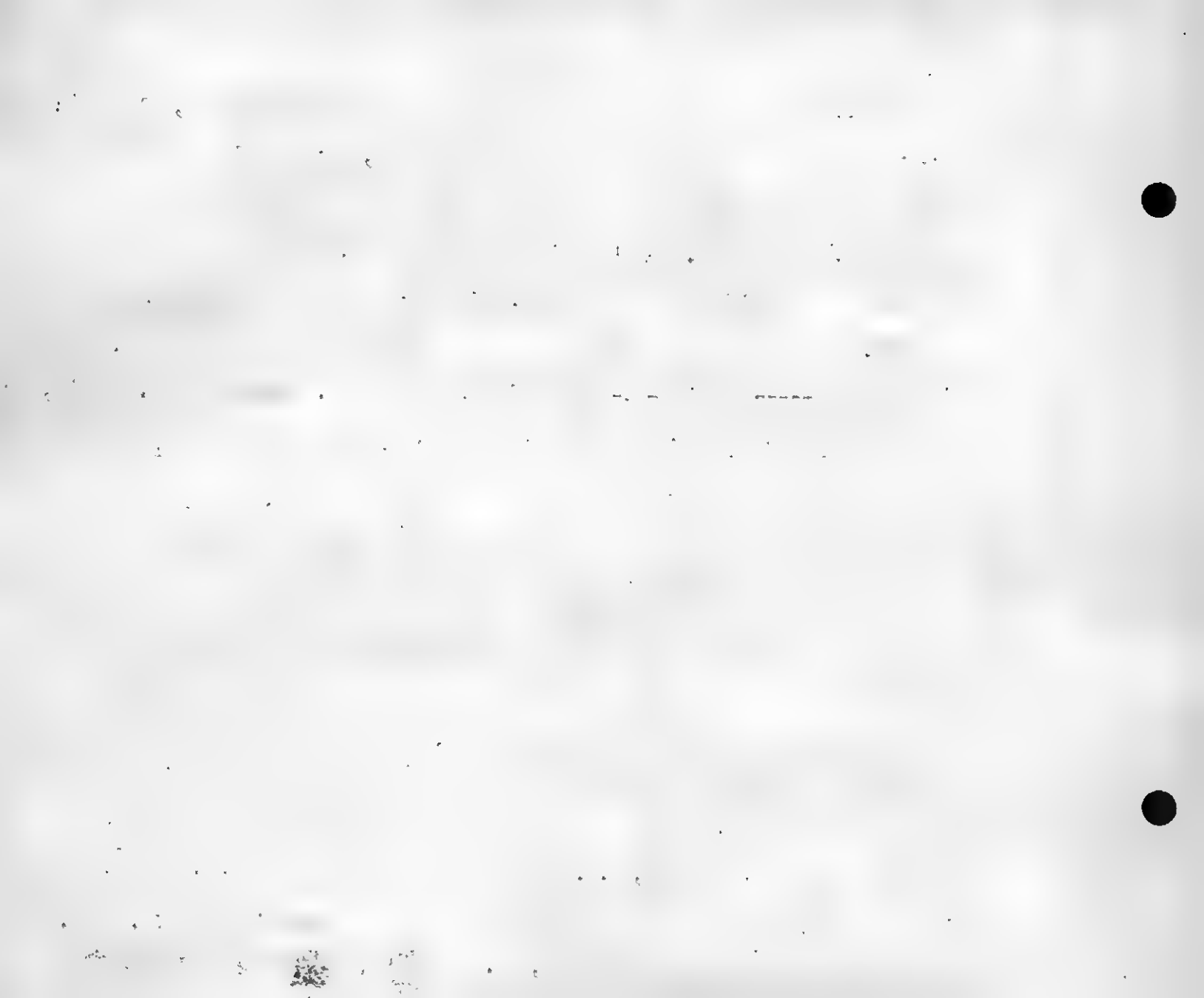


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) SAMUEL						2a. DATE OF DEATH FEBRUARY 8, 1968			2b. HOUR 4:30AM			
3. SEX MALE		4. RACE NEGROID		5. DATE OF BIRTH FEBRUARY 15, 1886			6. AGE (In years last birthday) 81 YRS.		7. UNDER 1 YEAR MONTHS		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH DORCHESTER Md.					
10. CITY OR TOWN OF DEATH WILLIAMSBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S REST HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER PARK LANE				
14. FATHER'S NAME First DAVID Middle WARD Last WARD				15. MOTHER'S MAIDEN NAME First PRISCILLA Middle WARD Last WARD								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO		16b. SOCIAL SECURITY NO. 215-18-4825		17. INFORMANT Address ROSIE WARD 605 W. LAFAYETTE AVE. BALTI, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest: a condition aggravated by influenza DUE TO, OR AS A CONSEQUENCE OF (b) influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4/2/68 DUE TO, OR AS A CONSEQUENCE OF (c) Art. rheumatic fever Hypertensive Cardiac PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Internal Inguinal Hernias										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10dys 10 yrs		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11/10/65 , 19____, to 4/8/68 , 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.												
22b. SIGNATURE HAROLD B. PLUMMER, M.D.					DEGREE DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/1/468					
22d. PHYSICIAN'S NAME (Type) HAROLD B. PLUMMER, M.D.					22e. ADDRESS Preston Maryland D.C. Box 158							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/15/68		23c. NAME OF CEMETERY OR CREMATORY MEEKINS NECK			23d. LOCATION (City or Town) (County) (State) MEEKINS NECK DOR. MD.					
24. FUNERAL DIRECTOR Helwick C. McClain				ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR FCR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

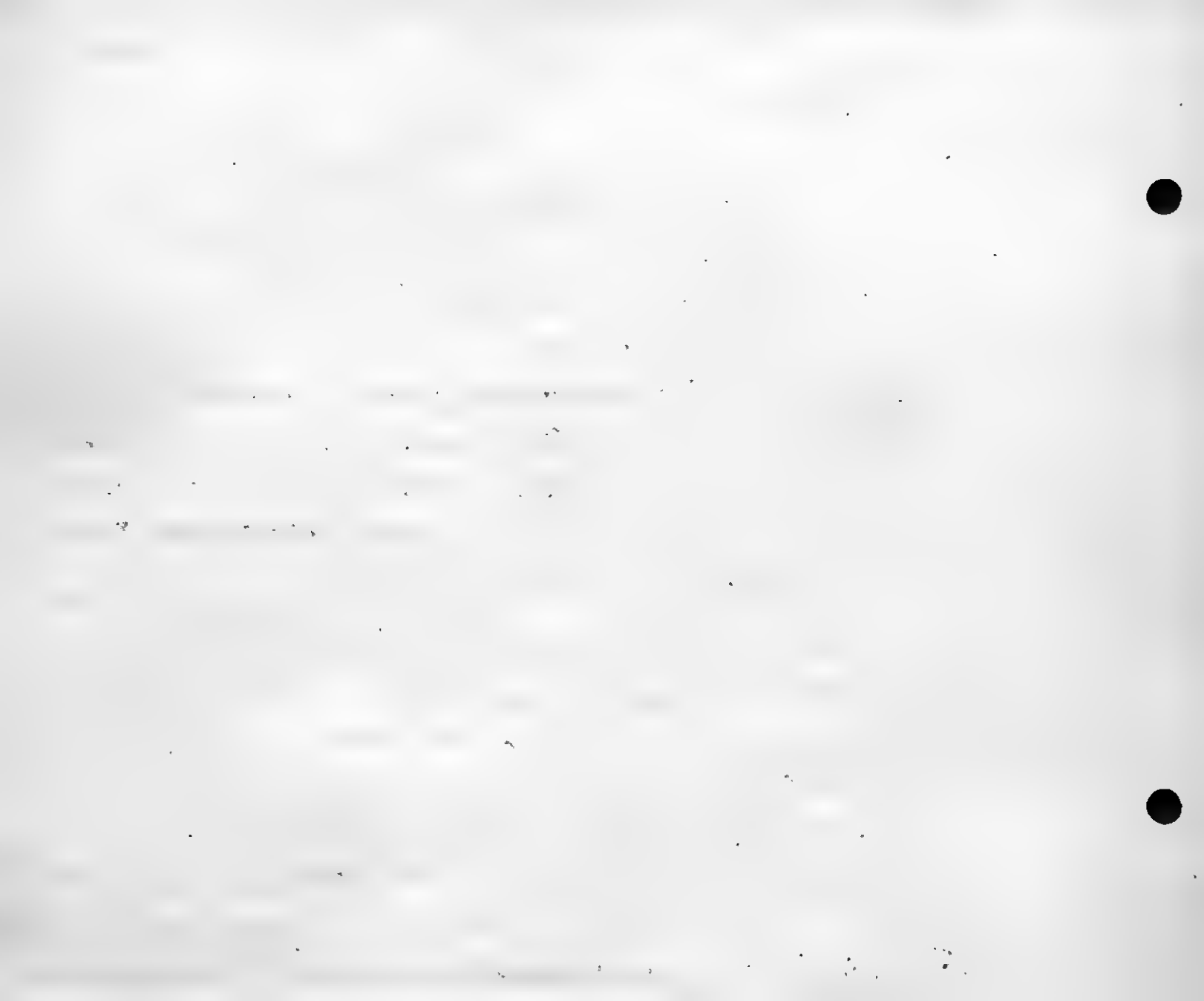


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-68

02573										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										2551																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
Robert C. Whittington										Month 2 Day 20 Year 68										1:05 P.M.																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS																								
M			N			9-29-1887			89 YRS.			MONTHS			DAYS																								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																														
Maryland			USA						Dorchester County Md.																														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY																								
Cambridge					Eastern Shore State Hospital					FARMER																													
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INS. OR CITY LIMITS?					13e. STREET AND NUMBER																			
Maryland					Somerset					Marion Station					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																																		
George Whittington					SARA WARD																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT																													
NO					215-38-0354					Medical Records Eastern Shore State Hosp.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC BRAIN SYNDROME</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
															DAYS																								
															YEARS																								
															YEARS																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
<u>DIABETES MELLITUS</u>																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
					HOUR A.M. Month Day Year P.M. 19																																		
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION																													
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>11-30-1967</u> to <u>2-20-1968</u> , that (I) (we) last saw the deceased alive on <u>2-19-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE															DEGREE					ATTENDING PHYS.					MED. DIRECTOR					STAFF PHYS.					22c. DATE SIGNED				
<u>Leandro M. Brea</u>																				<input type="checkbox"/>					<input type="checkbox"/>					<input checked="" type="checkbox"/>					<u>2-20-68</u>				
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS																								
<u>LEANDRO M. BREA</u>															<u>EASTERN SHORE HOSP. - CAMBRIDGE, MD</u>																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																								
<u>Cremation</u>					<u>Feb 26-1968</u>					<u>Branch</u>					<u>Marion Somerset MD</u>																								
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE																			
<u>Norma J. Ward</u>															<u>Marion Sta. Md.</u>					DATE <u>FEB 26 1968</u>					<u>Charles Jones</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02574										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02560																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										2b. HOUR																																							
Mary Elizabeth Williams										Feb. 22nd 1968										7:45 P.M.																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										Aug. 20, 1890										77 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH																													
Maryland										United States																				Dorchester																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Harlock Md. 21643										Bellevue Nursing Home										Housewife										None																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										Caroline										Ridgely										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										R.F.D.																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
John C. Smith										Mary Ellen ?																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										216-38-3808										Claribel B. Windsor, A.P.N.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										Cardiac Decompensation (auricular Fibrillation)										Impos																																							
4120																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
(b)										Hypertensive Cardiovascular Disease																				10 yrs																													
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)										Generalized arteriosclerosis																				25 yrs																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
Had Influenza about 4 weeks ago										Diagnosis by										Tytte																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																																							
										19																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 7/12/65 19 to 2/22/68 19, that (I) (we) lost saw the deceased alive on 2/16/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Harold B. Plummer M.D.										2/24/68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
										Reston Maryland																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Cremation										2-25-68										Greensboro										Greensboro Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
J.E. Bouclair										Greensboro, Md.										DATE FEB 27 1968										Charles Judge																													

033-20

RECEIVED

033-20

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>James Walter Willson</i>			First Middle Last			2a. DATE OF DEATH Month Day Year <i>February 6, 1968</i>			2b. HOUR <i>4:45</i> A.M.
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 5, 1880</i>		6. AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Norchester</i> Md.			
10. CITY OR TOWN OF DEATH <i>Hurlock Md. 21643</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Belle Haven Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Merchant Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Continental Cas</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>Baltimore Md</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8710 Wilson Ave.</i>	
14. FATHER'S NAME First Middle Last <i>Francis Thomas Willson</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Virginia Gardner</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not of unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-03-2006</i>		17. INFORMANT Address <i>Charles B. Under Hurlock Md. 21643</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral & coronary Insufficiency</i> <i>4/20</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4/20</i> (b) <i>Arteriosclerotic Cardio Renal Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>15 yrs</i> <i>25 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Priest's aggr pertr</i> <i>Post Influenzal 2 wks Multiple basal cell s Carcinoma of skin ophy</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/27/64</i> , 19__, to <i>2/6/68</i> , 19__, that (I) (we) last saw the deceased alive on <i>2/5/68</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE <i>Arnold B. Plummer</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/7/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Arnold B. Plummer M.D.</i>				22e. ADDRESS <i>P.O. Box #158 Preston Caroline Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 8</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Federalism Car. Md</i>			
24. FUNERAL DIRECTOR <i>Harvey Willson</i>				ADDRESS <i>Federalism Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	

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